THE Justin FOUNDATION

The War on Addiction

Inadequate Regulation, Standards and Oversight Allow Untrained, Unskilled and Unethical Counselors to Jeopardize Lives, Health and Recovery

A review of public records regarding California substance abuse treatment facilities. 2000 - 2006

October 2007

Executive Summary

The War on Addiction

Inadequate Regulation, Standards and Oversight Allow
Untrained, Unskilled and Unethical Counselors
To Jeopardize Lives, Health and Recovery

While political leaders waged war on drugs, California's substance abuse treatment professionals have quietly waged their own battle against addiction, an insidious enemy that preys on people, fills our prisons and brings crime into our communities.

One out of every nine Californians suffers from drug or alcohol addiction, and eight out of every 10 felons sent to state prisons are substance abusers, according to the Little Hoover Commission. In 2003, it found addiction costs California's economy $32.7 billion annually and takes an incalculable toll on society as a whole.[i]

The good news is treatment can work. For every $1 spent on treatment, the Little Hoover Commission found $7 is saved.[ii] The bad news is some of our front-line troops do not have the education, experience or expertise to effectively battle addiction, and the system has done little to remedy the shortcomings.

These professionals must confront a life-threatening disease in an extremely vulnerable population. Their decisions and actions have far-reaching impacts on the clients they treat, as well as the rest of society, which must bear the costs and consequences of addiction. The majority of substance abuse treatment professionals are doing their best with the knowledge and training they have. But they need more education, training and experience than currently required by California's minimum standards to effectively attack addiction and care for the vulnerable people with whom they are entrusted.

The Justin Foundation, a nonprofit organization dedicated to assisting individuals and families affected by drug abuse, reviewed public records to document the problems in California's residential treatment facilities and found untrained, unskilled and unethical treatment staff:

- Contributed to clients' deaths
- Risked clients' health
- Violated clients' rights
- Endangered the public
- Jeopardized recovery

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Some 200,000 Californians seek help with substance abuse every year. But without adequate oversight of the people and programs providing treatment – and little focus on the quality of that treatment - our state is losing the battle against addiction.

The Department of Alcohol and Drug Programs (DADP) oversees the state's substance abuse treatment. Regrettably, its' policy is to only conduct an on-site review of each residential treatment facility once every two years. It also investigates complaints and most of the deaths in these facilities.[iii] DADP does not name the counselors or staff causing the problems in its reports, and it has not kept track of those counselors. The Justin Foundation reviewed DADP's reports of investigations at residential treatment facilities where it issued its two toughest civil sanctions – Class A and Class B deficiencies – from 2000 through 2006. DADP limited its release of records to those where investigations had been completed.

Carelessness, Lack of Training Contribute to Deaths and Injuries in Treatment

DADP provided The Justin Foundation with files for 67 death investigations. Of those, the agency cited failures by the staff or the facility in 27 (40 %) of the cases. While some failures had little to do with the client's death, investigators found instances of staff members who ignored suicidal warning signs, did not exercise proper supervision of the people in their care and did not guard against recovering addicts' most common problem – relapse. Among the findings:

- A man just released from a hospital's mental health unit committed suicide after a counselor refused his request to return to the hospital.[iv]
- A parolee just released from prison died from an overdose after counselors at his treatment program failed to check him for drugs after an unusually long solo "shopping" trip to a nearby store.[v]
- A man died while waiting to be admitted to a drug treatment program.[vi]
- A man undergoing withdrawal from drugs died after the staff admitted him to the detoxification unit without the medications he needed for several serious medical conditions, including heart disease and emphysema.[vii]
- An alcoholic with a history of seizures during detoxification died while under the supervision of another resident – rather than the trained staff who were supposed to be monitoring the detoxification unit.[viii]
- One woman died after two staff members refused to provide cardiopulmonary resuscitation (CPR) because, one of them said, she was too "freaked out." [ix] (At least one CPR trained staff is required at every licensed treatment center.)
- Another resident died after the counselor working on him briefly abandoned CPR to make phone calls to his supervisors – even though there was someone else nearby who could have made the calls.[x]

Unskilled Counselors Endanger Public and Clients

Safety and security should be the watchword for any residential facility. But The Justin Foundation found that poor oversight by unskilled treatment staff has placed those in treatment in jeopardy. Among the findings:

- Four residents of a Southern California treatment center were hospitalized with injuries after a van driven by another resident fishtailed out of control and rolled onto its side. The facility used residents, rather than trained staff, to drive residents to 12-step meetings. The resident driving the van admitted he was inexperienced at freeway driving in the vehicle. [xi]

- A female resident who had repeatedly described panic attacks and other emotional turmoil to staff at another Southern California facility overdosed on aspirin. DADP found the staff had failed to seek any additional evaluations or mental health services for the disturbed resident.[xii]

- A mentally challenged resident – with no substance abuse problem - ended up so seriously injured he was "choking on his own blood" after drug treatment center staff tried to "restrain" him. Neither the staff nor the facility was qualified to deal with a mentally challenged person, but they kept the resident there despite repeated instances of bizarre and dangerous behavior that should have served as clear signals he was beyond their control.[xiii]

Of all places, a substance abuse treatment facility would be expected to conscientiously follow the rules governing the storage and administration of medication. Nevertheless, The Justin Foundation's review of complaint investigations filed between 2000 and 2006 found 59 violations of rules governing medication administration. Staff improperly stored, distributed and illegally prescribed medication to residents. They also provided unauthorized medical services. Among the findings:

- A woman overdosed the same day she checked into treatment after the staff let her keep a bag of prescription medication and syringes.[xiv]

- The staff stockpiled such large quantities of drugs at one treatment center that DADP referred the facility to the state Pharmacy Board for a follow-up investigation.[xv]

- Four facilities improperly prescribed medication to residents, including one facility where a nurse was allowed to determine what medication new residents needed.[xvi]
- Unskilled treatment staff at another treatment center mishandled prescription medication and exposed a diabetic resident to Hepatitis C by allowing a resident with Hepatitis C to use another resident's insulin vial.[xvii]

Unskilled counselors' lapses in judgment and inadequate supervision have endangered the public. Among the findings:

- Three teens were stabbed and a fourth injured in a fight with four inmates who slipped out the window of a recovery center in Northern California. The counselor who was supposed to be supervising them was at a neighboring facility.[xviii]
- A 3-year-old boy died of methadone poisoning after drinking his aunt's take-home medication from a Bay Area treatment facility. The staff at the facility had allowed the aunt to take the medication home, even though they knew the woman's live-in partner was still abusing drugs and that she was caring for a 3 year old.[xix]
- A male resident molested a child at a Southern California treatment center after the facility ignored its own policy of using only female residents as babysitters for children staying at the center.[xx]

Unethical Counselors Jeopardize Recovery

Unethical counselors can jeopardize their clients' recovery by luring them into sexual relations or causing them to relapse, as at least three staff members did. Among the findings:

- A substance abuse counselor aide provided alcohol to former residents who had just left treatment and engaged in sexual activity with them at her apartment. She also had sexual relations with a resident in her office at the treatment facility. [xxi]
- A staff member at a Northern California center lured a resident into a sexual relationship. The investigators could not determine if the relationship was consensual [xxii]
- A staff member at a treatment center in Oakland had sexual relations with three clients.[xxiii]

The Justin Foundation also found untrained staff violated the rights of those undergoing treatment and – in some cases - placed them in jeopardy. Among the findings:

- A resident, who was allowed to stay in a Long Beach facility, even though he had been drinking, got into a fight, was knocked unconscious and had to be transported to a hospital. At least one staff member claimed to have no knowledge of the state regulation requiring the intoxicated resident's removal from the facility.[xxiv]
- A program director violated residents' rights to be treated with dignity by shouting obscenities at them and having them work on his personal home.[xxv]
- A supervisor at a Bay Area facility threw food and food containers at a resident.[xxvi]

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Well-trained, experienced and ethical counselors presumably would ensure those in recovery get the services they need in a safe and secure setting. DADP investigators found fire and safety hazards at multiple facilities and instances where the most basic rules were ignored. Investigators also found residents performing drug tests on their fellow residents in treatment, a task that could have subjected the residents performing the tests to undue influence from their peers. In addition, 16 facilities misled potential clients by advertising services they did not or could not legally provide.

Ethical treatment professionals would presumably ensure facilities where they work comply with state regulations. Yet, that was not the case at 30 facilities housing more residents than permitted by their licenses or at the five treatment centers that admitted juveniles into adult programs without the appropriate waivers.

For decades, the lack of any certification or licensing scheme for counselors has meant a counselor who got in trouble at one facility could move on to another treatment center. Unless the new employer checked with the previous employer and was voluntarily given information, there would be no way of knowing the counselor had behaved unethically. No state agency or licensing board tracked misbehavior by name. All tracking by DADP was based on the facility where it occurred.

California Falls Short of Other States in Addressing Staff Failures

The Little Hoover Commission, in its 2003 report on the state's substance abuse system, urged DADP to professionalize the state's alcohol and drug abuse treatment work force.[xxvii] Four years later, the best that DADP can do is put in place regulations that require just 30 percent of counselors in drug treatment programs to be certified or licensed by 2010.

At that rate, it will take nearly **17** years to certify all the state's counselors.

Moreover, California's counselor certification standards are among the lowest in the nation – even though California has the largest population of people in treatment. Boards in 44 other states have adopted much more stringent requirements for their counselors, as indicated in the accompanying chart.

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Comparison of California and Other States Counselor Standards

California Certification Requirements	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC) - Adopted by boards in 44 other states[xxviii]
155 hours formal education	270 hours formal education
160 hours supervised practicum	300 hours supervised practicum
One year experience	Three years experience

For alcohol and drug abuse counselors in private practice it is even worse. There is no requirement for education, training or experience in the private sector in California – even though 26 other states require licensure.

In California, nine private organizations – rather than the state – are the agencies tentatively empowered to certify Alcohol and Other Drug Abuse (AOD) Counselors. These organizations must require the minimum California Certification standards outlined above. But they may implement higher standards if desired. So far, only one organization, the California Association of Alcohol and Drug Abuse Counselors, has chosen to implement requirements for counselor certification that meet the higher IC&RC standards.

Each of the nine certifying organizations has a different Code of Ethics resulting in different versions of violations and sanctions for certified AOD Counselors. This means a counselor certified by one organization may experience a completely different sanction (if any) for the same unethical behavior than a counselor certified by a different organization would face.

Additionally, since there is no counselor tracking and little accountability, AOD counselors who lose their certification from one organization can ostensibly apply to another certifying body and receive new certification without repercussion or detection.

Proposition 36 adds Pressure to an Overloaded System

The impact these counselors' actions can have on public safety became even more significant with the July 1, 2001 implementation of Proposition 36, the initiative requiring treatment instead of prison for certain nonviolent drug offenders. Nearly 50,000 drug offenders a year qualify for treatment instead of jail under Proposition 36, and that has changed the substance abuse treatment population. Most substance abusers voluntarily sought treatment before. Now a significant percentage of those in rehabilitation programs are ordered there by courts.

Conclusion

Much of addiction treatment originally grew out of the social structure model taught by Alcoholics Anonymous (AA) that began in 1935. Community based groups were, and still are, a valuable resource for individuals fighting addiction to alcohol and other drugs. These groups are peer-assisted, which is where the idea of recovering addicts helping struggling addicts originated. Members do not receive drug education or professional counseling and while this model definitely has its place in assisting addicts in recovery, much has been learned in the last 72 years regarding treatment for substance abuse.

Modern research has offered evidence-based treatment models scientifically proven to promote recovery when used for specific drugs of abuse. Physical cravings for several commonly abused illicit drugs can be minimized with new medically supervised drug treatment therapies. Emotional healing and co-occurring disorders, that often trigger relapse, can be addressed with Cognitive-Behavioral Therapy. [xxix] But these new methods must be learned and implemented to realize results.

In many instances, California is still working with an antiquated predominately peer-assisted social model. Programs and staff that a few years ago were merely weak, have now been stretched to the breaking point by an influx of Proposition 36 recipients. When the service base is weak, mounting additional programs on top of that base, like Proposition 36, is akin to building on a house of cards.

To produce the favorable success rates desired for Proposition 36 and the treatment industry as a whole, California's service base must be strengthened by shifting state requirements to more professional standards for treatment staff and research driven "best practices" methodology for treatment programs.

In 2003, the Little Hoover Commission accurately identified weaknesses in California's alcohol and drug abuse treatment system saying it was fragmented and lacking in the accountability and professionalism needed to give addicts a genuine opportunity for recovery. [xxx] DADP responded with counselor certification standards that are among the lowest in the nation. We believe our research, which is more fully detailed in the following pages, has just begun to scratch the surface of the serious shortcomings in this industry. Arming those on the front lines – our addiction treatment workforce – with more education, experience and expertise along with empirically based treatment programs and more supervision over facilities will help California score more victories in its long-running war on addiction.

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Preface

The Justin Foundation, which prepared this report, is a nonprofit organization dedicated to assisting individuals and families affected by drug abuse and to furthering formal education and certification of substance abuse counselors. Our goal is for every drug treatment facility to be a safe place for those who desire healing from addiction.

For this report, The Justin Foundation surveyed public records, including the Department Alcohol and Drug Programs' (DADP) own investigations of violations at the state's residential treatment facilities to determine the depth of problems caused by a lack of education, experience or expertise in the field of drug and alcohol abuse treatment. This report also relies on public records from the Department of Social Services, the Little Hoover Commission and other governmental agencies.

The Justin Foundation has purposefully chosen not to list the names of individual facilities cited by DADP. Our goal is to increase awareness of consumer protection and treatment needs. It is our explicit hope that the facts disclosed in this report will spur legislation and regulation to protect the consumer from substandard - even injurious - care that currently occurs within the addiction treatment community. We do not wish to disparage or discourage those who have experienced problems in the past - but to encourage raising the standard of care for every treatment recipient in the future.

Even though the names of specific facilities referenced are omitted and locations generalized within the pages of this report, all available complaint numbers are included in footnotes. Copies of specific reports may be requested in writing from DADP under the California Public Records Act. In cases where complaint numbers are not provided, DADP had redacted case numbers, dates and names from information provided because it contended this was necessary to avoid violation of federal confidentiality regulations.

Citations imposed by DAPD under the California Code of Regulations, Title 9, do not encourage facilities to better the level of their treatment care. The Justin Foundation believes that the seriousness of the violations is not reflected in the consequences imposed by the State. Following is a list of DADP's categories of deficiencies, its definition of those categories, the fines and timetables for corrections:

Class A Deficiency	Violation that places residents in imminent danger	Must be corrected immediately	Fine: $50 per day beginning immediately
Class B Deficiency	Violation that poses a potential danger to health and safety of residents	Fine: $50 per day beginning on 31st day after discovery, if left uncorrected	
Class C Deficiency	Health Code violations; don't endanger residents	Fine: $25 per day, if left uncorrected after 30 days	

The maximum daily civil penalty for all deficiencies is $150 per day. Compared to some facilities charging more than $20,000 per resident for treatment, the impact of these civil fines is negligible.

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Chapter One

Untrained Counselors Risk Clients' Lives, Health and Recovery

Carelessness Contributed to Deaths

DADP began investigating deaths in residential facilities in 2000, and it does not investigate all deaths. Out of the 67 death investigations from 2000 to 2006 that The Justin Foundation was able to obtain from DADP, the state's investigators found failures by staff or the facility in 27 (40 %) cases. While some of the failures had little to do with the client's death, investigators found instances of staff members who ignored suicidal warning signs, did not exercise proper supervision of the people in their care and did not guard against recovering addicts' most common problem – relapse. Following are the reports on a few of these investigations:

- In 2002, treatment staff ignored a client's cries for help, and the client hung himself. The client had visited his psychiatrist the day before his suicide, and the psychiatrist had increased the client's medication. A counselor working the day shift told the night staff member to take the client to the psychiatric emergency facility if the client needed help. When the client asked to go to the hospital at 9:45 p.m, the night staff refused the request, saying there was no one to provide transportation. At 10:40 p.m., another resident informed the staff that the suicidal client was "exhibiting inappropriate behavior." Again, no action was taken. Nearly eight hours later, the suicidal client was found hanging in the shower.[xxxi]

- Part of a counselor's job is monitoring for relapse. But the staff at one treatment facility did not exercise appropriate care with a client who had just been released from prison in 2003. A parole agent dropped the client off at the facility, and the client quickly got permission to go to a nearby Target store to buy clothes and shoes. He was gone for nearly five hours. This long absence apparently did not raise the staff's suspicions because they did not search him for drugs when he returned. He was found overdosed in the bathroom 90 minutes after his return. DADP cited the facility for "inadequate supervision".[xxxii]

- Los Angeles police tried to help one substance abuser by taking the intoxicated person to a detoxification facility in hopes he could safely withdraw from the drugs and/or alcohol he consumed. The man died at that facility while waiting for someone to help him. After the police dropped him off, the man followed the directions of the staff and waited for assistance. He went to the bathroom, emerged and found a couch on which to recline. Later – the report does not say how much later – the staff discovered the man was not breathing and his skin was "ashen." The staff could not find a pulse. The paramedics arrived and pronounced him dead. DADP did not issue any citations in this case.[xxxiii]

- A long-time substance abuser with a known history of heart disease, emphysema, black-outs, delirium tremens and Hepatitis C died in a detoxification unit where he had been admitted without any of the medications needed to treat his chronic health conditions, according to a DADP investigation of the 2001 death. The facility was a "social model" detoxification unit – not a medical one equipped for medical emergencies during withdrawal. The resident who died had been to the facility several times before, and he had four medications in his possession during five previous admissions: Albuterol, Lotensin, Digoxin and Pepcid. The medical records also indicated he took Phenobarbital for seizures. On his final admission to the facility, DADP found he had no medications in his possession. It cited the center for failing to complete a medical questionnaire and for failing to identify medical problems, including the resident's lack of medications, when he was admitted to the 50-bed facility.[xxxiv]

- At a recovery program in the San Diego area, a client died of an overdose in 2004 after returning from an outing. He returned to the program in the evening, when no staff was monitoring the residents' arrivals. DADP cited the facility for failing to monitor residents' arrivals, saying the staff had no way of knowing if the resident had brought drugs back with him or was under the influence of drugs when he returned.[xxxv]

- At a facility in Northern California in 2004, an alcoholic with a history of seizures when going through withdrawal died while under the supervision of residents – rather than the trained staff who were supposed to be monitoring him while he underwent detoxification. During the two hours before he died, the only person who checked on him was another resident, according to DADP's investigation. At 9 p.m., while under the supervision of the resident, the man was found lying face down and unresponsive on the hallway floor near the men's detoxification area. He was pronounced dead an hour later at a nearby hospital. DADP cited the center for violating its own guidelines by having residents – rather than staff – monitoring the man during withdrawal. DADP also cited the center for failing to complete the required health questionnaire that would have noted the man had a history of seizures during detoxification. In addition, the agency cited the facility for having a staff member who had no CPR certification.[xxxvi]

- After a resident died of cardio-respiratory arrest in 2003, DADP investigators found the staff at the facility had violated state regulations by allowing the resident to return to the treatment center after the resident admitted drinking two glasses of wine at dinner. State regulations specifically prohibit anyone under the influence of alcohol or drugs to be on the premises of treatment facilities – unless that person is undergoing detoxification or withdrawal. DADP found the facility had a "two-strike" policy that allowed residents to stay at the treatment center after a first offense if they underwent intensive counseling. The facility's director told the investigator that no one under the influence of wine or drugs was allowed on the premises, and he said he would not have allowed the resident back into the facility after drinking wine, if he had been aware of that fact.[xxxvii]

- A suicide investigation at a facility in 2003 found the resident who had killed herself was under the influence of alcohol on two occasions and allowed to remain at the facility. The first time, the woman was caught drinking in her room. The second time, staff and residents reported she was intoxicated when she was readmitted to the facility after Christmas. DADP cited the facility for violating state regulations requiring the removal of intoxicated residents from facilities without a detoxification license.[xxxviii]

Critical Life-Saving Skills Missing

DADP requires each licensed residential treatment center have at least one person on duty that is certified to perform cardiopulmonary resuscitation and provide first aid. CPR is a basic skill needed in working with any medically vulnerable population. It is especially important when dealing with addiction because of the possibility of relapse and the chronic illnesses that often accompany long-time substance abuse. Yet DADP found that facilities often failed to provide this basic service -- that there was no one on staff licensed to perform CPR. In at least one case, the staff knew how to perform CPR but failed to use it when it needed.

- The staff members at one large facility had the proper training and CPR certification. But when the time came to try to save a dying woman, the two staff members on duty refused to provide CPR, even though the woman was no longer breathing. One admitted that when she saw the dying woman's condition, she "freaked out" and "didn't want to perform CPR." The paramedics came to a different conclusion when they arrived 12 minutes later. According to the DADP investigator's report of the 2003 incident, they administered CPR and other life-saving procedures for 30 minutes. The woman died. DADP cited the facility for failing to have a person on duty who could administer CPR and for failing to have staff capable of recognizing the early signs of illness and the need for professional assistance.[*xxxix*]

- A staff member at a rehabilitation facility in Southern California found it more important to alert colleagues than to continue CPR on a suicidal resident who had hung himself in the facility's shower in 2003. The employee began CPR on the resident and, after detecting no pulse, went to call 911 and two colleagues – even though another resident was nearby who could have made the calls. The staff member then resumed CPR and continued until the paramedics arrived. The paramedics found a pulse and transferred the suicidal resident to a trauma center where the resident was admitted in critical condition, but subsequently died. DADP cited the facility for failing to have someone on staff who could administer CPR. They also found the facility did not have records documenting its own requirement for supervision of the suicidal resident every 30 minutes while undergoing detoxification. It had records of its supervision on others days, but the record of the day the resident killed himself was missing from the log book when DADP's investigator arrived. The facility also had no evidence the resident's case manager had seen him twice a day, as required in the treatment center's manual of operations.[xl]

Insufficient Training and Supervision Endangers Clients

In recovery, counselors often deal with difficult clients who may suffer from mental illness and substance abuse. Intake staff not adequately trained to recognize co-occurring disorders cannot successfully determine if their facility offers appropriate services to treat the client. State regulations require patient assessment upon admission and do not allow facilities to provide services not specified in their license.

- A resident who had just been released from a hospital emergency room because he was suicidal checked into a treatment center where he told a nurse and a case manager at the facility that he was thinking about killing himself. The case manager responded by praying with him and having the resident sign a contract promising not to harm himself. The resident subsequently committed suicide by cutting his wrists – just as he had described to the case manager. It was the facility's second suicide in seven months. The resident's stepbrother told investigators he had chosen the treatment center because its' website indicated it was competent in treating dual diagnosis and had psychiatrists at the facility. DADP criticized the facility's policies for monitoring suicidal cases and for making misleading statements regarding licensure and services provided by the facility. In addition, it was discovered that some of the facilities' counselors were not registered with a certifying organization.[xli]

- A parole agent placed a mentally challenged parolee – who had no substance abuse problem - at a Los Angeles substance abuse treatment facility because the staff told him they could keep the parolee locked inside the facility and administer medication to him. The facility was not licensed to provide the services, and the parole agent said he was not told that it did not have the ability to work with these types of clients. The parolee exhibited bizarre behaviors, including burning items in his room, on four occasions in the month before the altercation. Investigators said these incidents should have been enough for the staff to know they were not capable of dealing with this resident. Instead, the treatment staff allowed the parolee to stay and, on July 26, 2005, the parolee became belligerent. Staff said they tried to restrain him. In the altercation that followed, he was injured so badly that his parole agent said he was "bleeding from the mouth and making choking sounds on his own blood."[xlii]

- At a Long Beach area facility, one resident struck another resident in the back and then knocked another unconscious in May 2004. The unconscious resident was taken by ambulance to the hospital and never returned to the treatment program. The resident taken to the hospital was intoxicated. At least one member of the staff did not know state regulations required the removal of intoxicated residents from programs without detoxification units. DADP cited the program for failing to protect the residents' rights, allowing an intoxicated resident to stay in the program, failing to determine that two of its residents were free of tuberculosis and not having the required commercial license to drive a 10-person van. [xliii]

Chapter Two

Unskilled Counselors Endanger the Public and Clients

Medication and Medical Mistakes Risk Clients' Health

Of all places, an alcohol and drug abuse treatment facility would be expected to conscientiously follow regulations governing the storing and administration of medication. Yet, state investigators found 59 instances between the years of 2000 and 2006 where treatment staff violated these regulations by improperly storing, distributing and even illegally prescribing medications or by offering medical services.

- At a facility in the Costa Mesa area, a new resident overdosed the same day she checked into the program in 2003. Two members of the staff had agreed to let her keep syringes and a bag of prescription drugs – rather than locking them in the medication cabinet. Other residents questioned the counselors' decision and reported watching the new resident take a handful of her pills. In addition, the resident manager told another counselor the new client was "inappropriate" for the facility because she was a danger to herself. Yet there was no evidence the facility's medical director or clinical director provided a clearance to admit the new resident. DADP found the facility did not properly control medication or provide adequate supervision.[xliv]

- At a Long Beach facility, a client was exposed to Hepatitis C after a staff member provided the client's insulin vial to another diabetic resident. The resident who borrowed the insulin vial had Hepatitis C. He drew insulin from the vial, injected himself and then reused the syringe to draw more insulin from the borrowed vial. In doing so, he potentially contaminated the insulin with Hepatitis C. The investigator found this event "placed both residents in imminent danger and serious physical harm" and put other residents in an "unhealthful and unsafe environment." The counselor in the case was fired, and the facility cited for unsafe operations.[xlv]

- In 2003, the staff had stockpiled such large quantities of controlled medications at a Northern California treatment center that DADP's investigators cited it for a health and safety violations and referred the facility to the state Pharmacy Board for a follow-up investigation. The facility changed its policy for handling medication after the investigation.[xlvi]

- Staff at a treatment center considered putting a resident who relapsed on methamphetamine into a "higher level of care" but decided to wait because the resident's family was coming the next day for a visit. The resident met with his family, then left the treatment center and killed himself by jumping in front of a train. The staff said they were not aware of state regulations prohibiting someone who has relapsed from staying in their program because it did not have a detoxification license.[xlvii]

- At a facility located in the Sacramento area, the staff and program director admitted they had failed to report unconscious episodes and hospitalizations of a diabetic resident in their program in 2004. They told DADP they were unaware they were required to report such incidents.[xlviii]

- In 2003, DADP cited a facility in Southern California for violating state regulations by providing medication to residents without a prescription and providing TB injections to its residents. The state investigator found the facility kept bulk supplies of various prescription drugs and handed them out to residents when the centers' doctor determined the medications were needed.[xlix]

- DADP cited one central California facility for violating state regulations when its medical director prescribed methadone for a resident with an opiate addiction in 2002. The facility was not licensed to provide medical services.[l] The facility said this had only happened once, and the medical director and staff were instructed not to let it happen again. No corrective action was taken.[li]

- A 2003 investigation of one resident's death led to investigators discovering a nurse essentially prescribing medication to new clients. When a new resident checked in without a prescription, the nurse would determine if medication was needed and how much was needed. The nurse would then obtain the medication from the facility's medication supply and give it to the client. DADP cited the facility for providing medical services, saying this was an "imminent danger to the residents" and demanding the practice be "abated immediately." The investigator also found the facility failed to destroy valium left behind by the resident who died, and two staff members did not have current TB test results.[lii]

Poor Supervision Endangers Others

Unskilled counselors' lapses in judgment and inadequate supervision have endangered the public.

- In Northern California, the counselor who was supposed to be supervising inmates in a drug furlough program was at a neighboring facility when four of the inmates forced open a window and escaped in 2004. The inmates got into a fight with a group of teenagers in a nearby park, and three of the teens were stabbed and another injured in the melee. DADP's investigator found the center had no information on the inmates' criminal records and cited the center for violating its contract by failing to have a staff member on the premises round-the-clock. The center has since surrendered its furlough program's license.[liii]

- A 3-year-old boy died from methadone poisoning in 2000 after drinking his aunt's take-home medication from a Bay Area narcotic treatment program. DADP investigators said the staff at the facility should have foreseen the possibility of problems with this client. The staff knew the client was caring for her sister's 3-year-old son and that her "significant other" had tested positive for cocaine and morphine. The investigator said the drug abuse should have been a "red flag" for the center's staff. In instances like this, the treatment staff can require the client to come to the office for all methadone doses. At the least, the investigator said the staff should have discussed with the patient how to safely store methadone at home.[liv]

- In Southern California, a male resident molested a child staying with her mother at a treatment center in 2004. DADP found the facility violated its own policies by allowing a male resident to babysit the child while her mother attended a required group counseling session. The treatment center's policy only allowed female residents to babysit other residents' children. The facility re-instituted its policy of only allowing females to babysit after the 2004 incident.[lv]

Poor Oversight Places Those in Treatment in Jeopardy

The men and women who enter substance abuse treatment programs often have taken risks with their health and their lives through their use of illicit drugs and alcohol. Once they check themselves into a residential treatment center, they and their families expect skilled staff will provide adequate supervision to protect the recovering substance abusers from further harm. State regulations governing residential treatment centers hold these centers accountable for the supervision of the facility and those living at the facility. Yet these centers sometimes fail to protect those who have been entrusted to them.

- Four residents of a Southern California facility were injured and taken to the hospital for treatment after a van driven by another resident fishtailed out of control, rolled onto its left side and began sliding. The resident was taking six residents and himself to a 12-step program. He told DADP's investigator that he was not experienced at driving the van on the freeway. The center always used residents for this type of transportation because it did not have enough staff to perform this function, according to DADP. State regulations allow residents to help at treatment centers but say they "shall not be used as substitutes for required staff." The center agreed to stop using residents to drive other residents.[lvi]

- Courts often sentence offenders to treatment, especially since the enactment of Proposition 36. So a substance abuse treatment center would be expected to be responsive to legal requirements for its residents to comply with court orders. Nevertheless, the staff at one facility in Southern California admitted a resident, treated him for four months and then discovered the center could not fulfill the court's order that the resident undergo a DUI program in 2005. The resident had let the staff know at the outset that he needed to complete this program, and staff confirmed they knew he had a legal issue. DADP said the facility could have contacted the court or obtained a copy of the court's order to determine if it would be able to assist the resident in meeting the court's order. DADP cited the facility for failing to adequately supervise its resident.[lvii]

- A female resident overdosed on aspirin and had to have her stomach pumped at a nearby emergency room after the staff failed to recognize repeated signs that she was experiencing an emotional and/or psychological crisis. Over a three-day period prior to her attempted suicide in September 2002, the staff at the facility recorded three instances of the female resident suffering panic attacks or being highly agitated. Yet the facility's records show no indication the counselors ever considered the woman's condition warranted another evaluation or intervention by a mental health professional, according to DADP. On the first day, according to the facility's reports, the female resident had a panic attack. She was rocking in her seat, clenching her fists repeatedly, scratching the back of her head and neck and hyperventilating. The next day, the resident suffered another panic attack. She slapped her open hand against the wall and pointed her finger at her head like a mock gun. On the third day, the resident told the staff she "felt like she just shot a bunch of dope." She also told the staff she was entering her "manic phase." Each time, the staff spoke with her and reported she seemed calmer. On the fourth day, she overdosed on aspirin. DADP's investigator could not determine how the resident obtained the aspirin because the resident had since been discharged. The investigator did find the two drawers containing medication were unlocked – a violation of the center's own regulations. The investigator also cited the facility for failing to report this incident to DADP and for having a staff member who did not treat residents with dignity. Treatment centers are required to report any incident that results in an injury to a resident that requires medical treatment. They are also required to treat residents with dignity.[lviii]

Chapter Three

Unethical Counselors Jeopardize Recovery

Risks Associated with Sexual Relations and Relapse

By the time most addicts find their way into treatment, they have already tried to kick their habit numerous times and failed. They need expert help to restore their confidence and help them beat this devastating disease. When their counselors act unethically, the person providing the help can jeopardize the recovery of the person in need of help.

- At one facility, a resident who had a sexual relationship with a counselor told another counselor she was in "danger of relapse" and had almost taken a drink because she was so upset about her relationship with her counselor. She expressed shame at staying in touch with the man after trying to end the relationship and told another counselor she felt sick and broken even after the man had resigned from the facility in 2003.[lix]

- In Northern California, one staff member reported that another staff member had entered a resident's bedroom, climbed into bed, fondled and kissed the resident. This accusation was only partially confirmed because neither the staff member who reported the incident nor the resident who was reportedly fondled could be interviewed in person. But the staff member who reported the incident had provided a written account. [lx]

- Each of the nine counselor certifying organizations have developed their own Code of Ethics, but most of them say counselors should not develop a romantic relationship with those they serve and should not exploit them sexually, financially or emotionally. In 2002 at a facility in Oakland, DADP investigators found a staff member had engaged in both consensual and allegedly non-consensual sexual acts with at least three female residents as well as repeatedly exposing himself to and sexually harassing other female residents. The investigator also found another staff member entered into a personal relationship with a resident shortly after that resident's discharge from the facility. The facility fired both counselors.[lxi]

- In Los Angeles County, a substance abuse counselor aide had sexual relations with a resident in her office at the treatment facility in 2005. A witness also told investigators the aide provided alcohol to eight former residents of the treatment facility shortly after the residents were released from treatment and engaged in sexual activity with those former residents at her apartment. The facility denied any knowledge of these transactions and fired the aide.[lxii]

Counselor Relapse Endangers Residents' Safety and Recovery

California currently has nine counselor certifying organizations, each with its own code of ethics. All address the issue of counselors who are in recovery relapsing. Generally, these codes of ethics say counselors must recognize intoxication and relapse in themselves, seek treatment and protect the residents they serve from any negative consequences of their behavior.

- At a Southern California facility, state investigators found the director intoxicated and a counselor who admitted to drinking and was suffering from alcohol withdrawal. [lxiii]
- Review of a facility in Northern California showed that in 2005 a staff member who tested positive for methamphetamine was allowed to remain at the facility for two more months before he was fired for being under the influence of illegal drugs while working there.[lxiv]

Physical Abuse and Resident Exploitation Violates Rights

The duty of every treatment facility and every employee of those facilities should be to maintain a professional attitude when interacting with residents and to "do no harm." Sadly, that is not always the case. Some treatment facilities claiming to help ill people beat their addictions have instead exploited them.

- In 2004, the supervisor of a San Francisco treatment facility threw food and containers of food at a resident, hitting him in the face. Four residents who witnessed the incident provided varying reports of what was thrown. Among the items reported were hamburgers, a jar of mayonnaise and French fries.[lxv] In February 2005, an investigator looking into complaints at the same facility confirmed that another staff member had threatened residents with bodily harm and instructed other staff to discipline residents, even though residents had not violated any house rules.[lxvi]
- In 2006, staff required residents at one treatment facility to surrender their passwords for their Electronic Benefit Transfer cards so the facility could use the residents' food stamp allocations to purchase food for the program. Nothing in the residents' admission agreements or any other document in their files required them to help purchase the food.[lxvii]
- At a Sacramento area facility, the program director shouted obscenities at residents and had them painting, digging, installing sprinkler systems and performing other tasks at his personal residence. Every previous and current resident interviewed by DADP confirmed both these points. While some said they did not feel "forced" to work on the program director's home, they did say they felt "intimidated" at times and were worried about the consequences if they declined the program director's request for them to work. DADP also found the center used residents as staff, putting them in charge of other residents' medication, writing up disciplinary reports on other residents and performing drug tests on residents – all tasks that could have put them under pressure from their peers. DADP cited this facility for 10 separate violations of state regulations and rules governing treatment centers. .[lxviii]

Counselors and Programs Mislead with False Claims

Counselors were working at each of the following three facilities that were making promises they could not keep and/or promoting services they could not legally provide.

- An exclusive six-bed facility in the mountains of Southern California that advertises its Pacific Ocean views, promised medically supervised drug and alcohol detoxification in 2005 – services it couldn't legally provide under the license it held from DADP. DADP cited it for making false claims.[lxix]

- Another Southern California facility had a brochure and other marketing material claiming the 30-bed treatment center's "compassionate and sensitive team of professionals include a medical director who is certified as an addiction specialist by the American Society of Addiction Medicine." Yet, the center's medical director had no such certification. DADP cited the facility for false advertising in 2000.[lxx]

- At another facility, a document given to residents when they arrived at the program told them they would meet with psychiatric staff to "receive whatever medications are indicated to…aid with their detoxification." The 10-bed facility did not have a license to provide detoxification services, and its staff denied it provided those services. But interviews with residents in 2004 revealed they had used drugs within 24 hours of their admission to the facility – a violation of the treatment center's license. Under state licensing regulations, only facilities with detoxification services may admit residents who have used drugs or alcohol in the previous 24 hours.[lxxi]

Current Requirements Ignored

DADP oversees facilities, rather than staff. Its requirements focus on health and safety, rather than the quality of those providing counseling and other services. But facilities are only as good as the people running them. A review of DADP complaint investigations found several violations of basic regulations by facilities – violations that ethical counselors and administrators would not permit.

- Juveniles are restricted from admission to adult residential treatment facilities without special permission. Yet in 2001, investigators found a 15 year old[lxxii] and a 16 year old [lxxiii] living at separate recovery centers along the coast. In 2005, another facility admitted a 17 year old without an adolescent waiver. The administrators subsequently provided more training to their staff and imposed a new protocol requiring a copy of a driver's license prior to admission to prove each new resident is legally an adult.[lxxiv] Investigators also found a 15 year old receiving methadone from a Central Valley facility without parents' permission. A woman claiming to be the stepmother of the 15 year old had enrolled him in the narcotic treatment program and subsequently admitted to investigators that she was only an acquaintance.[lxxv]

- The maximum occupancy of each facility is clearly defined in its license yet, between 2000 and 2006, investigators found 30 treatment centers that exceeded their licensed capacity. At a San Diego area facility, three of the residents even claimed to be counselors in an apparent attempt to help the facility avoid a sanction.[lxxvi] Each center quickly reduced their population to comply with their license.

- A facility in the Bakersfield area violated state regulations by employing four residents as "junior client service providers." These residents assisted with the facility's drug tests and administration of over-the-counter medications to other residents. Both of these duties could expose the junior client service providers to undue influence from other residents to cover up a "bad" drug test or provide medication the resident was not supposed to receive. DADP's investigator also cited the treatment center for offering detoxification services without a proper state license. The investigator found the center had a "crisis bed" where it housed people who had used alcohol or drugs within the previous 24 hours. The managing administrator told the investigator that the facility frequently accepted residents who had consumed illicit substances within 24 hours of admission. State regulations prohibit offering detoxification services without proper licensing. The managing director notified DADP that the facility had stopped offering detoxification services.[lxxvii]

- At a facility in Oakland, DADP's investigator found a six-bed facility was not providing bath linens or basic meal service – even though it promised three meals a day in the admission agreements signed upon admittance. The investigator visited the facility in May 2003 and found the treatment center did not even have sufficient silverware for six people or adequate cooking utensils for food preparation. The investigator also found several instances of spoiled or rancid food and food items kept past their expiration dates. The investigator cited the facility for requiring one resident to perform construction work on the facility. Three of the four smoke detectors did not work, and the investigator cited the facility for failing to protect residents against fire hazards and failing to keep the facility in good repair. A bathroom was under construction. Carpeting in other areas of the building was frayed and torn. Lights were missing their covers, and one bedroom had exposed sheetrock.[lxxviii]

- State regulations require treatment centers be clean, safe, sanitary, and in good repair at all times for the safety and well-being of residents, employees and visitors. Yet DADP investigators found numerous instances where facilities did not meet that requirement. At one Bay Area facility, the investigator notified the Fire Department of a fire hazard at the facility because the accumulated grease on a commercial gas cooking appliance and the cooking oil stored nearby created the potential for a fire. During the 2003 investigation, the facility was cited for keeping feral cats on the premises. The investigator also found evidence of rodent infestation in the center's food storage shed, a bloody pool of fluid on the bottom of its freezer which appeared to have come from partially defrosted meat kept above the freezer and unsafe defrosting of chicken. The 49-bed center did not have soap or towels for hand-washing in any of its four bathrooms or its two kitchens. Six light fixtures did not have covers and carpeting on the steps was torn creating a tripping hazard.[lxxix]

- In 2003, a Northern California facility was cited for numerous upkeep failures and for failing to protect residents from fire hazards. DADP's investigator notified the County Fire Marshal's Office of hazards after finding a two-bedroom "withdrawal" house had no working smoke detectors. They found 14 light switches and two electrical outlets without covers, exposed wiring in the laundry room, mold growing in a soft drink dispenser, two rooms so cluttered that the exits were partially blocked and food debris accumulated on the stove and the walk-in freezer. In addition, the facility had failed to notify the state that it had changed its administrator or that it was using a nearby cabin as a residential treatment area.[lxxx]

- One facility had two residents living in a trailer with no plumbing or running water that was parked on its grounds when DADP's reviewer responded to complaints there in 2003. DADP cited the facility for failing to notify it of the trailer's installation. The investigator also found the 22-bed facility had two more people than permitted under its license, and the two vans the facility used to transport residents were in poor condition. State regulations require vehicles used to transport residents be maintained in a safe operating condition. Yet, one of the vans had a window that would not roll up or down, and the seat belts on the rear bench seat were on the floor and out of passenger reach. The second van had a front door that would not open, a right vent window closed with duct tape and the seat belts on the rear bench seat were on the floor and out of reach of passengers.[lxxxi]

Conclusion

Help Win the War on Addiction by
Arming Substance Abuse Professionals with Education, Experience and Expertise;
While Increasing Supervision and Focusing on Quality of Care

In 2003, the Little Hoover Commission found California's alcohol and drug abuse treatment system was fragmented and lacking in the accountability. It said professionalism was needed to give substance abusers their best opportunity at recovery. [lxxxii] DADP responded with regulations that require just 30 percent of counselors in treatment facilities be certified or licensed by 2010.

Certification requires only 155 hours of formal education and one year of experience. While this is an improvement over no regulation, the low standards mandated by current regulations potentially endanger public safety, the health and safety of those in treatment and their chances at recovery.

Implementation of Proposition 36 increased the need for additional treatment space and DADP has focused almost exclusively on the *quantity* of treatment and staff without paying enough attention to the *quality* of both.

UCLA's 2007 Evaluation of the Substance Abuse and Crime Prevention Act Final Report (SACPA) stated:

> *"The implementation of SACPA resulted in a substantial increase in demand for treatment services across the state. The number of individuals referred to treatment through the criminal justice system doubled in SACPA's first few years, with a large increase in the number of heavy users. Treatment capacity is being increased across the state but lags behind the demand for residential placements for heavy users. Many counties maintain long-term residential treatment waiting lists and many referrals that might otherwise have been placed into long-term residential treatment were placed into outpatient drug free treatment instead."*
>
> *"Little was known about who receives what kind of treatment under SACPA, their experiences in treatment, and how treatment-placement and experiences affect treatment outcomes such as treatment completion, and criminal recidivism."*

As evidenced in this report, neither those entering treatment voluntarily nor those sentenced there by a court have any assurance they will be in a safe place or a place where facility administrators, staff or counselors have the education, training, skills or experience to legitimately assist substance users in their recovery.

Even if a person completes treatment, their future may well depend on whether they underwent an empirically based treatment program. Under the current system, they have no way of knowing and no guarantee that the treatment they receive is evidence-based.

Stronger supervision, an enhanced focus on quality of care and arming those on the front lines – our addiction treatment workforce – with more education, experience and expertise will help California score more victories in its long-running war on addiction.

Better supervision and higher standards for treatment as well as the system's workforce also will help the state's bottom line by saving $7 in costs associated with addiction (courts, jails, police, healthcare and unemployment) for every $1 spent on increasing supervision and raising standards.

The Justin Foundation supports recommendations, which are attached to this report. We invite and encourage our state leaders and policy makers who have focused on the war on drugs to join us in a renewed battle against addiction. Addiction is the enemy destroying our families, endangering our communities and robbing our children of their futures – and sometimes their lives.

Cathie Smith, Mom
President and Founder
The Justin Foundation

The Justin Foundation
Supports the following Educated Recommendations

1) Lead from Strength
Create a cabinet level position for Secretary of Alcohol and Drug Policy "to coordinate treatment and prevention programs, social services, law enforcement and alcohol control" as advanced by Join Together in their 2006 Blueprint for the States.[lxxxiii]

2) Establish a Council on Alcohol and Drug Control Strategy
Implement the 2003 Little Hoover Commission recommendation to formulate a unified strategy that includes all state agencies affected by drug and alcohol problems. This council should develop cross-boundary strategies and set quantifiable goals.[lxxxiv] This council should report directly to the Secretary of Alcohol and Drug Policy.[lxxxv]

3) Employ Requirements for Proven Treatment Programs
Exercise state's rights to purchase evidence-based treatment programs. In recent years, scientific knowledge has proven specific therapies effective for substance abuse treatment.[lxxxvi] Experts in the field have clearly indicated that quality of treatment is as critical as access to treatment. Emphasis on quality of care must be given equal consideration as access to care. When poor care results in poor patient outcomes, access to treatment becomes not only irrelevant, but can also be counterproductive.[lxxxvii]

4) Fund Automation
Replicate systems currently in use at the Office of Consumer Affairs. Data tracking of complaints at the DADP is currently manual, which bogs down workloads and makes analysis extremely burdensome. Computerization of this data is essential for efficient and effective management and wise decision-making. In addition, tracking of problematic counselors is currently non-existent and critical for consumer protection.

5) Raise Counselor Certification Requirements
Adopt minimum standards for education, training and experience of Alcohol and Other Drug (AOD) counselors comparable to the majority of other states in our nation. 44 State Boards have adopted standards meeting or exceeding those set by the International Certification and Reciprocity Consortium (IC&RC).[lxxxviii] California requirements for AOD Counselors are significantly below these standards!

6) Standardize Ethics, Violations and Sanctions
Develop a comprehensive Code of Ethics, definition of corresponding violations and a range of applicable sanctions utilized by all counselor certifying organizations and enforceable by the state. The diversity represented by nine certifying organizations results in the inability of consumers to know under which Code of Ethics and qualifying requirements counselors are operating. The absence of uniform violations and sanctions makes it impossible for counselors to anticipate consequences of violations.

7) Introduce Licensure to Offset Workforce Shortage

Create a Substance Abuse Counselor license regulated by the Board of Behavioral Sciences on par with licensed clinical social workers and marriage and family therapists. Experts agree licensure would allow SACs to advance careers to a true professional standing with corresponding wages -- resulting in a more stable long-term workforce. Licensed SACs could be utilized to supervise and/or mentor certified counselors.[lxxxix]

Retain counselor certification as a paraprofessional position to satisfy interim workforce needs until licensure is implemented and to fulfill lower- to mid-level positions once full licensure is achieved.

8) Leverage State-Level Quality Control

The Washington Circle Group and The National Committee for Quality Assurance recommend rewarding treatment providers on a merit-basis which will produce a self-motivating impetus for treatment improvement.[xc] Influence problematic providers by increasing the level of state supervision to assist them in improving treatment efforts.

Establish a timeline for gradual conversion to purchasing based on merit: Fund treatment only from providers utilizing programs scientifically proven to be effective in treating substance abuse. Fund treatment only from providers who exclusively employ certified or licensed counselors trained to administer that treatment.

Focused quality control will produce more effective outcome results and ensure wise stewardship of public funds. [xci]

9) Safeguard Consumer Safety

The State should require criminal background checks and prohibit individuals with violent criminal and/or violent sexual assault convictions from becoming counselors.

To guard against relapsed counselors working with patients, random drug testing should be utilized similar to regulations involving other medical employees involved in patient care, i.e. emergency room physicians[xcii], nurses and pharmacists[xciii], scrub technicians[xciv], and emergency medical technicians[xcv].

10) Provide Adequate Funding

The Little Hoover Commission found that substance abuse treatment saves taxpayer dollars at a ratio of 7:1. But the investment must first be made in treatment and prevention before results can be realized. Financing the time lapse between investment and savings has been challenging. The National Governors Center recommends adopting a tax increase on alcohol and requiring private insurers to provide parity for substance abuse treatment.[xcvi] The Justin Foundation supports both of those alternatives as well as a bond to augment funding for the increased treatment program populace resulting from the enactment of Proposition 36.

Notes

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- [xi] DADP. Notice of Deficiency. Feb. 4, 2004.Complaint Investigation #03-142. Pages 1-2.
- [xii] DADP. Notice of Deficiency. Nov. 7, 2002.Complaint Investigation #02-66. Pages 1-6.
- [xiii] DADP. Notice of Deficiency. August 16, 2005. Complaint Investigation #05-28. Pages 1-8.
- [xiv] DADP. Notice of Deficiency. Oct. 9 and 10, 2003.Complaint Investigation #02-271. Pages 1-6.
- [xv] DADP. Notice of Deficiency. May 28-29, 2003.Complaint Investigation #02-223. Pages 1-6.
- [xvi] DADP. Notice of Deficiency. DADP marked out date and report number. Pages 1-3.
- [xvii] DADP. Notice of Deficiency. DADP marked out date. Complaint Investigation #03-205. Pages 1-5.
- [xviii] DADP. Notice of Deficiency. August 10-12, 2004.Complaint Investigation #04-31. Pages 1-3.
- [xix] DADP. Narcotic Treatment Program Licensing Report #01-90. Inspection Date May 16, 2000. Pages 5-7.

- [xx] DADP. Notice of Deficiency. Date marked out by DADP. Complaint Investigation #03-226. Pages 1-4.
- [xxi] DADP. Notice of Deficiency. June 2 and 27, 2005. Complaint Investigation #04-309. Pages 1-4.
- [xxii] DADP. Notice of Deficiency. DADP marked out date. Complaint Investigation #03-83. Pages 1-7.
- [xxiii] DADP, Notice of Deficiency. August 28-29, 2002 and Sept. 13, 2002.Complaint Investigation #02-16. Pages 1-9
- [xxiv] DADP. Notice of Deficiency. June 23, 2004. Complaint Investigation #03-278. Pages 1-7.
- [xxv] DADP. Notice of Deficiency. Oct. 12-14, 2004. Complaint Investigation #04-68. Pages 1-7.
- [xxvi] DADP. Notice of Deficiency. Feb. 8-11, 2005. Complaint Investigation #04-184. Pages 1-7.
- [xxvii] The Little Hoover Commission, March 11, 2003. "For Our Health and Safety: Joining Forces to Beat Addiction." Page xi. http://www.lhc.ca.gov/lhcdir/169/report169.pdf
- [xxviii] www.icrcaolda/AODAstandards.asp
- [xxix] HBO: Addiction, 2007 Home Box Office, Robert Wood Johnson Foundation, NIAAA and NIDA.
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- [xlii] DADP. Notice of Deficiency. August 16, 2005. Complaint Investigation #05-28. Pages 1-8.

- [xliii] DADP. Notice of Deficiency. June 23, 2004. Complaint Investigation #03-278. Pages 1-7.
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- [xlviii] DADP. Notice of Deficiency. Oct. 12-14, 2004. Complaint Investigation #04-68. Page 4.
- [xlix] DADP, Notice of Deficiency, April 8-10, 2003. Complaint Investigation #02-142. Page 2.
- [l] DADP. Notice of Deficiency. Nov. 25-26, 2002. Complaint Investigation #01-257. Pages 1-2.
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- [lvi] DADP. Notice of Deficiency. Feb. 4, 2004. Complaint Investigation #03-142. Pages 1-2.
- [lvii] DADP. Notice of Deficiency. April 4, 2005. Complaint Investigation #04-261. Pages 1-2.
- [lviii] DADP. Notice of Deficiency. Nov. 7, 2002. Complaint Investigation #02-66. Pages 1-6.
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- [lxiii] DADP. Notice of Deficiency. DADP marked out date. Complaint Investigation #00-212. Pages 1-6.
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- **[lxxxiv]** Little Hoover Commission 2003 Report, Pages v and 42;
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- **[lxxxvi]** Ken Stark, director of Washington state Mental Health Transformation Project and former director of the Washington Division of Alcohol and substance Abuse, panel member of Join Together;

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- [lxxxvii] 2003 Letter from David L. Rosenbloom, Ph.D., Director, Join Together, and 2003 Letter from Jerome H. Jaffee, M.D., Panel Chair, Join Together, both in "Rewarding Results; Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel. (www.JoinTogether.org/Quality).

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- [xc] "Rewarding Results; Improving the Quality of Treatment for People with Alcohol and Drug Problems," Join Together National Policy Panel. (www.JoinTogether.org/Quality).

- [xci] "Blueprint for the States," 2006 Findings and Recommendations of a National Policy Panel, Pages 23 – 24; and "Rewarding Results," Pages ii – 18, both Published by Join Together with support from the Robert Wood Johnson Foundation.

- [xcii] Pierce v. Smith, 117 F.3d 866 (5th Cir. 1997)

- [xciii] AFGE v. Derwinsky, 777 F.Supp. 1493 (N.D. Cal. 1991)

- [xciv] Kemp v. Claiborne County Hosp., 763 F.Supp. 1362 (S.D. Miss. 1991)

- [xcv] Piroglu v. Coleman, 25 F.3d 1098 (D.C. Cir. 1994)

- [xcvi] National Governors Center for Best Practices, Health Policy Studies Division, Issue Brief, October 11, 2002, page 7;
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